IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7005 1160 0000 1506 9452

August 25, 2008

Randal E. Barnes, Administrator
Canyon West Health & Rehabilitation Center
2814 South Indiana Avenue
Caldwell, ID 83605

Provider #: 135051

Dear Mr. Barnes:

On **August 15, 2008**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Canyon West Health & Rehabilitation Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567, listing Medicare/Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567 and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 8, 2008**. Failure to

submit an acceptable PoC by **September 8, 2008**, may result in the imposition of civil monetary penalties by **September 29, 2008**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **September 19, 2008 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 19, 2008**. A change in the seriousness of the deficiencies on **September 19, 2008**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 19, 2008** includes the following:

Denial of payment for new admissions effective **November 15, 2008**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 15, 2009**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a

separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 15, 2008** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **September 8, 2008**. If your request for informal dispute resolution is received after **September 8, 2008**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N.
Supervisor
Long Term Care

LT/dmj

Enclosures

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FAX 208-364-1888

September 3, 2008

Randal E. Barnes, Administrator
Canyon West Health & Rehabilitation Center
2814 South Indiana Avenue
Caldwell, ID 83605

Provider #: 135051

Dear Mr. Barnes:

On **August 15, 2008**, a Recertification, Complaint Investigation and State Licensure was conducted at Canyon West Health & Rehabilitation Center. Mark Sawmiller, R.N., Lorraine Hutton, R.N., Kari Davies, R.D., Lea Stoltz, Q.M.R.P. and Janice Ryan, R.N. conducted the complaint investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003691

ALLEGATION #1:

The complainant stated that an identified resident missed multiple tube feedings because of radiation treatments that conflicted with the feeding schedule. The complainant stated the resident went to late afternoon (3:00 or 4:00 p.m.) appointments at the cancer center on June 10, 13, 17, 20, 25, and 27, 2008. July 2008 appointments were on July 1, 8, 11, 15, 18 and 22. The complainant is concerned that the resident missed tube feedings during these times as subsequent appointments were rescheduled to avoid conflict with the tube feedings. The resident had at least seven more treatments to go.

FINDINGS:

The identified resident's record was reviewed as well as an additional record of a random resident receiving tube feeding.

The facility's registered dietitian (RD), a registered nurse (RN) unit supervisor, and an licensed practical nurse (LPN) who regularly assisted the identified resident were interviewed.

The identified resident received supplemental tube feedings due to poor oral intake at meals. When the resident had an appointment at the cancer center, the tube feeding ran longer the next day to ensure the entire volume was infused. The record revealed that the dietitian was carefully monitoring weight and tube feed tolerance. Nursing staff were aware of the need to run the tube feeding longer on days following appointments and the documentation in the record showed tube feed start and stop times as well as total volume infused. The facility ensured that the tube feed schedule also met the needs of the resident by scheduling feedings for when the resident would not be involved in other activities and able to go to the dining room for meals.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135051	A. BUILDING _____ B. WING _____	08/15/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON WEST HEALTH & REHAB CENTER	2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification and complaint survey of your facility. The surveyors conducting the survey were: Mark Sawmiller, RN, Team Coordinator Lorraine Hutton, RN Janice Ryan, RN Lea Stoltz, QMRP Kari Davies, MPH, RD, LD Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record FSM = Food Service Manager	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* RECEIVED SEP - 8 2008 FACILITY STANDARDS	
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined the facility did not ensure 1 of 15 sample residents (#4) and 2 random residents (#19 & #20) were provided care	F 241	**F-241** **Resident Specific** Resident #4's hair was combed and face shaved. CP updated to reflect provision of address excessive drooling and changing clothing, cleaning face as needed. Resident #19's hair was combed. Resident #20's hair was combed and face shaved.	09/18/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 9-8-08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 which enhanced their dignity. Residents were not provided assistance with grooming to present a dignified appearance. Findings include: 1. Resident #19 was observed on 8/12/08 at 7:00 a.m. seated in her wheelchair in the hallway, waiting to be assisted to the dining room. Her hair was disheveled and appeared to be uncombed. According to the 7/8/08 quarterly MDS, the resident was totally dependent on staff for dressing and personal hygiene, and was not understood by others when communicating. 2. Resident #20 was observed on 8/12/08 at 9:25 a.m. self propelling his wheelchair down the hallway from the dining room. His face was unshaved and his hair disheveled. He was dressed in pajamas. According to his 7/4/08 admission MDS, the resident required extensive staff assist for dressing and personal hygiene. 3. Resident #4 was observed on 8/11/08 at 8:10 a.m. in the dining room for breakfast. The resident appeared unshaved and his hair was disheveled. The resident was again observed at 9:00 a.m. seated in his wheelchair in the hallway outside his room. He was not able to control his saliva, which was running down his face and onto his shirt. Resident #4 was observed on 8/12/08 at 9:15 a.m. seated in his wheelchair in the hallway. His face appeared unshaved and his hair disheveled. The resident was not able to control his saliva and the front of his shirt was wet. The resident was again observed at 10:00 a.m. seated in his	F 241	**Other Residents** The other residents were checked and shaved if needed and their hair was combed. **Facility Systems** Nursing staff will be Re-In-Serviced regarding the resident hygiene. This will be completed before 9/18/08. Newly hired Nursing Staff will be In-Serviced on resident grooming during orientation. **Monitor** The Director of Nurses or designee will monitor during daily rounds for compliance. The results will be reported to the Performance Improvement Committee.	

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F 241	Continued From page 2 wheelchair outside his room. He was asleep with his head drooping and had saliva running onto his shirt. According to his 5/7/08 quarterly MDS, the resident required extensive assistance for dressing and personal hygiene. The DON and Administrator were informed of the observations on 8/14/08 at approximately 4:15 p.m. No further information was provided.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, family, and staff interview, it was determined the facility failed to provide an activities program that met the needs of 5 of 15 sampled residents (#s 2, 6, 8,10 & 21). This resulted in periods of time, up to 75 minutes, spent without meaningful activity or interactions during the pre-meal times. This was the case for several unidentified random residents as well. Findings include: During an observation of early morning cares on 8/12/08 at 6:40 am, Resident #2 was observed dressed, sitting on his bedside, requesting staff assistance to transfer to his wheelchair and, "Go for coffee." At 6:50 am the resident was observed sitting in the Paradise Dining room awaiting coffee which staff brought to him. Resident #2 sat	F 248	**F-248** **Resident Specific** Television was replaced in Paradise Dining room. Magazines will be placed in a holder for residents use. Residents have been interviewed to identify a selection of pre-meal activities they desire. **Other Residents** The Paradise Dining Room had the above-mentioned measures taken to provide a variety of pre-meal activities for all residents eating in that dining room to enjoy. **Facility Systems** Staff will be In-Serviced on providing pre-meal activities for residents and options that are available. **Monitor** Director of Nurses or designee will monitor on rounds to ensure compliance. Residents will be interviewed periodically with adjustments made regarding available activities being offered as needed. The results will be reported to the Performance Improvement Committee.	09/18/08

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F 248	Continued From page 3 alone at his table, drinking coffee until 7:25 am, at which time his wife arrived and sat with him. No music or television was turned on, neither were newspapers, or activity materials observed. The posted meal schedule for the Paradise Room stated breakfast was served at 8:00 am, lunch at 12:30 pm, and dinner at 6:00 pm. During an interview at 7:00 am on 8/12/08, the LN passing medications on the 200 hall, identified the Paradise dining room, as an, "Assisted" dining room. The LN stated that residents who were independent with eating ate in the "Green" dining room, resident's who were in a restorative eating program ate in the "Tropicana" dining room, and resident's who required some level of assistance ate in the Paradise dining room. During a family interview on 8/12/08 at 7:10 am, a family member complained that residents frequently sat in the dining room for, ..."An hour or more." waiting for their meals to be served. The family member stated she observed residents becoming increasingly restless for their meals to arrive because of the length of time they were sitting and waiting. The family member did not recall TV, music, or other activities generally being available while residents waited. During the time frame between 6:50 am and 7:25 am on 8/12/08, 10 more residents were brought to the dining room. Other than the staff who transported residents to the dining room and then left again, there was only one staff present. No music or television was turned on, neither were newspapers, or activity materials observed. Most resident's sat quietly at their tables not interacting with one another. One resident sat in the far	F 248		

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F 248	Continued From page 4 corner of the room intermittently calling out and talking to herself. Between 7:25 am and 8:00 am an additional 18 residents were brought to the dining room by staff. All residents, except Resident #2 who's wife sat with him, sat without social interactions or relevant activities until the breakfast trays arrived at 8:05 am. On 8/13/08 at 5:40 pm, 30 residents (Resident's #'s 2,6,8,10, & 27 random residents) were observed sitting in the Paradise dining room waiting for the evening meal. Four staff were in the room at the time. Two were assisting residents to take sips of fluids and two were placing clothing protectors on the residents. Water and fluids were placed on the residents' tables but several of the residents were unable to drink without assistance including Resident #'s 6, 8 and 10, who were observed to require verbal cues and some physical assistance to initiate eating and drinking. No music or television was turned on, nor were any type of activity materials observed. The meal trays arrived at 6:15 pm. Two CNA's interviewed at 6:15 pm and 6:20 pm confirmed that the lack of formal activities was typical prior to meals and many residents did sit and wait in the dining room for extended periods of time before trays arrived. One of the CNAs stated television and music were available to listen to but staff sometimes did not note they had not been turned on. Random Resident #21 stated that she and her table mates often sat for, " A long time." waiting for the meals without music, television, or ..."any thing to do but wait." Activity calendars reviewed for August 2008 listed no planned activities or stimulation for the pre-meal times. For example:	F 248		

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F 248	Continued From page 5 August 11, activities were posted as; 10:00 am - Resident Council 11:00 am - Exercise group 3:00 pm - Beading August 12, activities were posted as; 10:00 am - Coffee & Donuts 11:00 am - Exercise group 1:30 pm - Ladies nails 3:00 pm - Bingo 6:00 pm - Caldwell Night Rodeo August 13, activities were posted as; 10:00 am - Food Committee 11:00 am - Exercise group 1:30 pm - Craft Class 6:00 pm - Iron Pirates Party August 14, activities were posted as; 10:00 am - Cards w/residents 11:00 am - Exercise group 1:30 pm - Ladies nails 3:00 pm - Bingo 7:00 pm - Music makers The facility did not provide formal activities during the pre-meal hour and, with the exception of coffee and beverages available for those who could assist themselves, no informal opportunities for activity were observed. This resulted in residents sitting for 35 to 75 minutes without opportunities for meaningful activity or interactions while waiting for their meals to be served.	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	**F253** **Resident Specific** Resident #22 was assisted in organizing her belongings, excess clutter was removed and the room cleaned.	09/18/08

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F 253	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain a safe and orderly environment for 1 random resident (#22) and properly maintain wheelchairs for 3 additional random residents (#19, #23 & #24.) The findings include: 1. Resident # 22 was admitted to the facility on 5/17/01 with diagnoses of diabetes mellitus, congestive heart failure, obesity, depression, hypertension and was status post tibia fracture. The resident's 6/3/08 quarterly MDS stated the resident was independent in cognitive skills for daily decision making and had unimpaired memory. The assessment also stated the resident expressed repetitive health complaints and had sad, pained, worried facial expressions. Resident #22 had requested follow-up by survey staff for issues raised during a group interview. Surveyors went to her room on 8/12/08 at 2:40 p.m. to discuss the issues. Resident #22 was not in the room at that time. The resident's room was observed to contain the following: * 2 large cardboard boxes overflowing with newspapers, coffee mugs, yarn and other personal items stored on the bed. * 3 plastic boxes of beads, an overflowing tote bag, several plastic grocery bags and several dozen newspapers stacked at the foot of the bed.	F 253	Resident # 19's Wheelchair foot support was replaced. Resident #23's Wheelchair armrests were replaced. Resident #24 has been discharged from facility. **Other Residents** An inspection was done to identify other wheelchairs that had armrests and/or foot supports that need to be repaired or replaced. In addition, an inspection of other resident rooms has been conducted to identify other rooms for a safe and orderly environment. **Facility Systems** The Nursing staff will be Re-In-Serviced on the reporting cracked armrests or foot supports using facility's Maintenance Log. New Staff will also be In-serviced on this during Facility Orientation. **Monitor** The Maintenance Supervisor or designee will conduct random checks of the wheelchairs to ensure compliance. The results will be reported to the Performance Improvement Committee.	

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F 253	Continued From page 7 * 4 20 gallon plastic storage boxes and a large cardboard box filled with newspapers and books on the floor. * A plastic 3 drawer storage cart on wheels filled with craft supplies, papers and personal items. The cart was angled from the foot of the bed and further reduced the width of the aisle. * 2 over bed tables, the surfaces of which were completely covered with paint, craft supplies, personal items and condiments. * A large bookcase filled with books, puzzles and personal decor items. The depth of the bookcase from the wall, coupled with the width of the plastic storage boxes reduced the width of the aisle. Resident #22 required a bariatric bed. The items stored on the mattress covered approximately half the surface of the mattress. The box and storage containers significantly decreased the width of the aisle from the door to Resident #22's roommate's half of the room. The SW was interviewed on 8/12/08 at approximately 3:15 p.m. She stated the problem was one of long standing and provided documentation of past problem solving attempts. She also stated the resident slept at an angle due to the amount of items stored on the bed. On 8/14/08 at 8:30 a.m. a LN was interviewed about the condition of Resident #22's room. She stated the CNA's had to physically remove and replace all the stored items during linen changes to the resident's bed.	F 253		

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F 253	Continued From page 8 The Administrator and RN consultant were informed of the issue on 8/12/08 at 3:30 p.m. The Administrator stated a plan would be put in place to assist the resident to remove the potential hazards and clutter. 2. Resident #19 was observed on 8/12/08 at 7:00 a.m. seated in her wheelchair in the hallway, waiting to be assisted to the dining room. Her wheelchair was observed to have an upholstered foot support platform which was torn on the left corner. The foot support was also noted to be soiled with a white colored material. 3. Resident #23 was observed on 8/12/08 at 9:15 a.m. seated in his wheelchair in the hallway. The upholstery on the right armrest was cracked and torn, leaving a rough surface. 4. Resident #24 was observed on 8/12/08 at 9:15 a.m. seated in his wheelchair in the hallway. The upholstery on both armrests were cracked and torn, leaving rough surfaces. This is a repeat citation from the June 5, 2007 recertification survey.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	**F-280** **Resident Specific** Resident # 5's Care Plan was updated to reflect resident's current status related to dressing, oral care and other hygiene needs. Resident # 1's Care Plan updated including discontinuing the elbow and heel protectors and encouraging resident to wear geri-sleeves or other protection.	09/18/08

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F 280	Continued From page 9 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not revise care plans as related to changes in resident levels of assistance, and reassessments for 3 of 15 sample residents (#1, #5 and #6). Findings include: 1. Resident #5 was admitted to the facility on 3/4/08 with diagnoses of acute and chronic respiratory failure, aphasia, pneumonitis, profound mental retardation, seizure disorder, sleep apnea and status post gastrostomy. Resident #5's 5/29/08 quarterly MDS documented he was totally dependent on staff for all areas of ADL, mobility and received nutrition, fluids and medications through a gastrostomy tube. Resident #5's 3/4/08 Comprehensive Care Plan included an Occupational Therapy Care Plan sheet which identified ADL deficit areas of toileting, eating, bathing, dressing and hygiene. The Care Plan sheet was marked by hand "D'C [discontinue] 6/20/08". Further review of the care plan showed "ADL routine" problem identified	F 280	Resident # 6's Care Plan was updated by discontinuing problem related to anti-coagulation use & risk. **Other Residents** Residents' Care Plans have been reviewed and revised as appropriate related to ADL Assistance, use of heel & elbow protectors and anti-coagulation therapy. **Facility Systems** Licensed Nurses will be Re-In-Serviced on revision of resident care plans as resident's level of assistance changes. Interdisciplinary team will monitor to ensure that resident's care plan is revised to meet resident's needs in accordance to RAI Schedule. **Monitoring** DNS or designee will monitor through random chart audits for care plan revisions as needed. Minimum of four charts a week will be reviewed x one month. Findings to be reported to facility's Performance Improvement Committee for tracking & trending and further recommendations.	

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F 280	Continued From page 10 which included instruction to staff to shampoo/shower/bath the resident twice weekly. Resident #5 was dependent on staff for all components of ADLs. The Care Plan failed to provide specific information to staff for approaches to assist the resident in dressing, oral care and other hygiene measures. The DON was informed of the Care Plan concern on 8/12/08 at 3:30 p.m. 2. Resident #1 was admitted to the facility on 12/19/07 with the diagnoses of urinary tract infection, malaise and fatigue, hypoosmolality, anemia, dementia without behaviors, non-insulin dependent diabetes mellitus, osteoarthritis, hypertension, and depressive disorder. Resident #1's most recent quarterly MDS assessment, dated 7/1/08, documented the following: * Short-term and long-term memory problems * Moderately impaired cognitive skills for daily decision making a. Resident #1's care plan, dated 4/23/08, contained the problem, "Skin/tissue integrity impaired: potential R/T [related to] DM [diabetes mellitus] R/T impaired mobility/transfers." One of the approaches documented, "Heel/Elbow protectors." On 8/11/08 at 3:20 pm, Resident #1 was observed to be in his room, asleep in bed. No elbow or heel protectors were observed on the resident.	F 280		

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F 280	Continued From page 11 On 8/14/08 at 9:25 am, the DON was interviewed concerning heel and elbow protectors being on the resident's care plan. She explained that the resident had initially used the heel and elbow protectors, but now were no longer used and stated, "They will come off the care plan." b. On 8/12/08 at 11:35 am, Resident #1 was observed to be in his room, awake while in bed, and with geri sleeves on both arms. Review of Resident #1's care plan revealed no mention of geri sleeves used. On 8/14/08 at 3:00 pm, the DON was interviewed concerning Resident #1's geri sleeves not being on the care plan. She stated that the CNAs had initiated using geri sleeves on Resident #1 to protect the resident's skin, but they were not on the care plan. 3. Resident #6 was admitted to the facility on 6/26/06 and readmitted on 6/28/06 with diagnoses of dementia, atrial arrhythmia, aortic aneurism, osteoarthritis and osteoporosis. The 3/17/08 Care Plan problems included a risk for bleeding related to anticoagulation therapy, a related goal and seven interventions. The 8/1/08 Doctor's Recapitulation Orders did not contain an order for anticoagulants. On 8/14/08 at 9:30 am the DON was interviewed and confirmed that the Coumadin had been discontinued and the Care Plan was not updated to reflect this change. This is a repeat citation from the June 5, 2007	F 280		

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F 280	Continued From page 12 recertification survey.	F 280		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, it was determined the facility failed to complete comprehensive bladder incontinence assessments to determine a resident's individual voiding patterns, cause of incontinence, and approaches to assist the resident to maintain/regain normal bladder functioning if possible. This was true for 1 of 8 (# 2) residents reviewed for urinary incontinence. Findings include: Resident #2 was admitted to the facility on 5/24/08 with diagnoses of closed fracture of dorsal vertebrae, dementia without behaviors, anemia, and history of testicular cancer. The resident's quarterly MDS assessment, dated 8/05/08, documented: * Short term memory deficits * Moderate cognitive impairment * Limited assistance of one staff needed with transfers	F 315	**F-315** **Resident Specific** Resident # 2 has been assessed and new Bladder Status Evaluation completed and care plan updated as appropriate. **Other Residents** An audit was completed to identify other Bladder Status Evaluations that were incomplete. Those assessments are being conducted and care plans will be updated as appropriate to meet resident's current needs related to urinary elimination. **Facility Systems** Licensed Nurses will be Re-In-Serviced related to completion of the Bladder Status Evaluation. This will be completed before 9/18/08. **Monitoring** DNS or designee will monitor through random audits of Bladder Status Evaluation for completeness, including voiding patterns. A minimum of 4 charts will be audited a week for next month. Results will be reported to facility's Performance Improvement Committee for further recommendations based on results.	09/18/08

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F 315	Continued From page 13 * Extensive assistance of one staff needed for locomotion on the unit and toilet use * Occasional bladder incontinence The resident's initial MDS assessment, dated 5/31/08, documented no bladder incontinence. Flow Sheet Records for July 2008 and August 1 - 13, 2008 documented Resident #2 was consistently continent of urine on evening and night shifts but frequently had at least one episode of incontinence on day shift. The resident's Bladder Status Evaluation, dated 7/23/08, was incomplete. The evaluation listed only that the resident was incontinent, had never had surgery to correct a urinary condition, required extensive assistance with transfers to toilet, used a wheel chair as locomotion, and had functional incontinence. The evaluation concluded with the recommendation of routine toileting. The bladder evaluation did not give a history of the resident's incontinence, nor did it address possible contributing factors or the frequency and pattern of Resident #2's incontinence. The resident's Comprehensive Care Plan Report, dated 7/8/08, listed the following interventions for incontinence: * "Toilet with am and pm care, before meals and rest periods and prn" * "Assist to toilet when resident exhibits behaviors that may indicate need to void" During an interview on 8/13 at 2:40 pm the RN Unit Manager stated that no other bladder/incontinence assessment information was available for Resident #2. She also stated the primary time of incontinence for Resident #2	F 315		

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F 315	Continued From page 14 was following meal time and mostly after breakfast. She stated the resident did have a perception of the need to void but had difficulty getting to the bathroom quickly enough after meals. Resident #2's bladder evaluation failed to accurately reflect his individual problems with incontinence, including the times of day he was most likely to be incontinent. Because the resident's bladder evaluation was not complete and accurate, it did not provide information needed to develop effective individualized interventions including providing assistance immediately following breakfast. This is a repeat citation from the June 5, 2007 recertification survey.	F 315		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure fall prevention interventions were in place for residents. This affected 3 of 15 sampled residents (#s 1, 6, and 15). The findings include: 1. Resident #1 was admitted to the facility on 12/19/07 with the diagnoses of urinary tract	F 323	**F-323** **Resident Specific** Resident # 1 – Staff were re-educated on use of tether alarm while in bed upon identification of issue. Resident # 15 – Staff were re-educated regarding proper bed height. Resident # 6 – Staff were re-educated regarding use of floor mats while resident is in bed. **Other Residents** Chart audits have been completed regarding use of tether alarms, floor mats and bed height. Care Plans updated as appropriate and Nursing Staff have been re-educated regarding current interventions.	09/18/08

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F 323	Continued From page 15 infection, malaise and fatigue, hypoosmolality, anemia, dementia without behaviors, non-insulin dependent diabetes mellitus, osteoarthritis, hypertension, and depressive disorder. Resident #1's most recent quarterly MDS assessment, dated 7/1/08, documented the following: * Short-term and long-term memory problems * Moderately impaired cognitive skills for daily decision making * Total dependence of one person assistance for ambulation The facility completed a Falls Risk Assessment for Resident #1 on 12/19/07, which rated the the resident as, "High Risk." A Care Plan Update form, dated 5/12/08, was completed by the facility for Resident #1. It contained the problem, "Trauma, Potential for R/T [related to] Fall HX [history]." The approach documented, "D/C [discontinue] pressure alarm on bed. Attach Tether alarm to bed only." The 8/08 recapitulated physician orders contained the order, dated 5/13/08, "Tether Alarm." Resident #1's care plan, dated 4/23/08, contained the problem, "Trauma, potential for R/T Fall HX." One of the approaches, dated 5/18/08, documented, "Tether alarm to bed." On 8/11/08 at 3:20 pm, Resident #1 was observed in his room, asleep in bed. A tether alarm was observed to be placed on the bed near the pillow. Although the tether was attached to the resident, the alarm was not secured to the bed with the clip on the control box.	F 323	**Facility Systems** Nursing Staff have been Re-In-Serviced on implementing Fall Prevention measures according to resident's Care Plan. **Monitoring** DNS or designee will monitor through routine rounds to validate implementation of fall prevention interventions in accordance to a resident's plan of care. Tracking and trending of results of these rounds will be reported to facility's Performance Improvement Committee for further recommendations.	

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F 323	Continued From page 16 On 8/11/08 at 7:50 am, the CNA caring for Resident #1 was asked if the alarm should also be clipped to the bed. She answered, "Yes, he is a fall risk." Observations of the alarm not having been secured to the bed, although the tether was attached to the resident, occurred on the following dates and times: * 8/12/08, 9:15 am * 8/12/08, 10:05 am * 8/12/08, 11:35 am * 8/12/08, 1:35 pm * 8/12/08, 2:45 pm * 8/13/08, 9:40 am * 8/13/08, 10:55 am On 8/14/08 at 3:00 pm, the DON was made aware of the tether alarm being improperly placed multiple times. No further information was provided by the facility. 2. Resident #15 was admitted to the facility on 6/20/08 with the diagnoses of percutaneous transluminal coronary angioplasty, chronic ischemic heart disease, gastrointestinal hemorrhage, chronic airway obstruction, anemia, and hypertension. Resident #15's Medicare 30 day MDS assessment, dated 7/18/08, documented the following: * Short-term memory problems * Modified independent cognitive skills for daily decision making * Extensive assistance of one person for ambulation	F 323		

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F 323	Continued From page 17 The facility completed a Falls Risk Assessment for Resident #15 on 6/20/08, which rated the the resident as, "High Risk." Resident #15's care plan, dated 7/15/08, contained the problem, "Trauma, potential for R/T Fall HX." One of the approaches, dated 7/17/08, documented, "low bed." On 8/14/08 at 11:30 am, Resident #15 was observed in his room in a wheelchair while working with a physical therapist. The bed was in an elevated position for transfer. At 2:00 pm on 8/14/08, Resident #15 was in his bed, which was in an elevated position. A CNA was asked if the resident's bed was always kept in that position. She stated that the bed had probably been left in an elevated position for transfer by the physical therapist and that it also had been elevated for the resident's lunch in his room. She then put the bed back in the low position. On 8/14/08 at 3:00 pm, the DON was made aware of Resident #15's bed being left in an elevated position, although the care plan called for a "low bed." No further information was provided by the facility. 3. Resident # 6 was admitted to the facility on 6/26/06 and readmitted on 6/28/06 with diagnoses of dementia, atrial arrhythmia, aortic aneurism, osteoarthritis and osteoporosis. Resident #6's most recent quarterly MDS assessment, dated 7/13/08 documented the following: "fell in past 30 days"	F 323		

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F 323	Continued From page 18 Resident #6's Care Plan dated 3/17/08 documented for "Potential for Trauma related to dementia and falls at night." Interventions included, "MAT X 1 TO (L) (left) SIDE OF BED - TO BE TAKEN UP WHEN OOB (out of bed)." During observation on 8/12/08 Resident #6 was sleeping in bed at 6:40 am, 7:00 am and 7:30 am. A folded mat was seen leaning against the right side of the roommate's bed at those times. No mat was unfolded on the floor at the left of Resident #6's bedside. The DON and Administrator were informed of the observations on 8/14/08 at approximately 4:15 p.m. No further information was provided. This is a repeat citation from the June 5, 2007 recertification survey.	F 323		
F 329 SS=E	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	**F-329** **Resident Specific** Resident # 14 Behavior Monitoring tool was implemented on 8/14/08 for the month of August. Residents # 1, 3, & 2's chart was updated to reflect maximum daily does of Acetaminophen. Resident # 6 was assessed, physicians were contacted and an order received for a dose reduction of resident's Xanax.	09/18/08

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F 329	Continued From page 19 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility did not ensure that orders for acetaminophen and drugs containing acetaminophen included precautions regarding maximum dose per 24 hours, that behavior monitoring was in place for residents receiving psychotropic medications and that medications were not used for excessive duration. This affected 5 of 15 (#1, #2, #3, #6 & #14) sampled residents. The findings include: 1. Resident #14 was admitted to the facility on 3/13/05 and readmitted 3/20/08 with diagnoses of vascular dementia, chronic obstructive pulmonary disease, convulsions, depression and hemiplegia as a result of a cerebral vascular accident. According to the 6/1/08 recapitulation Physician Orders, Resident #14 received Depakote Sprinkles (anticonvulsant medication) 500 mg [milligrams] 3 times daily for dementia with behaviors, Lexapro 20 mg daily for depression and Risperdal (antipsychotic medication) for psychosis. Resident #14's 1/31/08 Care Plan, updated 8/13/08, stated under "Mental Illness" a goal that the resident "will not manifest sexually aggressive	F 329	**Other Residents** The charts for other residents with physician orders for medications containing acetaminophen have been updated to reflect maximum daily dose of acetaminophen. Other residents receiving psychotropic medications were reviewed during the week of 8/25/08 to regarding current targeted behavior monitoring and current dose of psychotropic medication. Based on this review, physicians were contacted with results of this review for dose reductions / adjustments. **Facility Systems** Nursing Staff have been re-educated regarding monitoring for resident's targeted behavior and for potential side effects and physician notification if noted. Also included was ensuring total maximum dose of acetaminophen is reflected in resident's chart as appropriate. Review of residents receiving psychotropic medications by the behavior committee will be done monthly.	

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F 329	Continued From page 20 behavior for the next 90 days." The Social Worker was interviewed on 8/14/08 at 1:45 p.m. and confirmed there was no behavior monitoring for sexual aggression, depression, or psychosis in place. After the interview, the SW placed forms for behavior monitoring in the resident record. She also stated the resident had displayed no sexually inappropriate behavior since his readmission. 2. Resident #1 was admitted to the facility on 12/19/07 with the diagnoses of urinary tract infection, malaise and fatigue, hypoosmolality, anemia, dementia without behaviors, non-insulin dependent diabetes mellitus, osteoarthritis, hypertension, and depressive disorder. Review of the August 2008 monthly recapitulation of physician orders and medication administration record revealed the following medications containing acetaminophen: * "Vicodin (Hydrocodone w/ [with] Acetaminophen) 5/500 mg PO BID [by mouth twice daily]" * "Vicodin (Hydrocodone w/ Acetaminophen) 5/500 mg 1 Tab[let] PO Q 4 Hrs, PRN [every 4 hours as needed]" * "Vicodin (Hydrocodone w/ Acetaminophen) 5/500 mg 2 Tabs PO Q 4 Hrs, PRN" * "Tylenol (Acetaminophen) 650 mg 1-2 PO/PR Q 4-6 hrs, PRN * "Darvocet-N 100 (Propoxyphene Napsylate w/ APAP) 1 PO Q 4 hrs PRN"	F 329	Upon admission and monthly, the DNS or designee **Monitoring** DNS or designee will monitor through chart audits to ensure that residents receiving medications containing acetaminophen have maximum daily dose reflected. Audit will also include validation of appropriate monitoring of targeted behaviors and/or side effects from psychotropic medications is in place with appropriate follow-up as needed. Tracking and trending will be reported to facility's Performance Improvement Committee for further recommendations. Upon admission and monthly the DNS or designee M.D. Added per phone conversation with administrator on 9/18/08 at 1200 p.m.	

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F 329	Continued From page 21 Table 1 of F329 (Unnecessary Drugs) stated the following concern with acetaminophen (Tylenol), "Daily doses greater than 4 grams/day [4000 mgs per day] from all sources (alone or as part of combination products) may increase risk of liver toxicity." The total potential daily dose from the Vicodin, Acetaminophen and Darvocet-N orders was 9,900 mg. No warnings not to exceed 4000 mg per day were found on the August 2008 MAR or recapitulation of physician orders. On 8/14/08 at 4:00 pm the Administrator and DON were made aware of the lack of warnings not to exceed 4000 mg for acetaminophen. No further information was provided by the facility. 3. Resident #3 was admitted to the facility on 6/6/08 and readmitted on 7/12/08 with the diagnoses of joint replacement right hip, type II diabetes, depressive disorder, and hypertension. Review of the August 2008 monthly recapitulation of physician orders and medication administration record revealed the following medications containing acetaminophen: * "Norco (Hydrocodone w/ [with] Acetaminophen) 10/325 mg 1 Tab[let] PO Q 4 Hrs, PRN [every 4 hours as needed] DX [diagnosis]: Mild pain" * "Norco (Hydrocodone w/Acetaminophen) 10/325 mg 2 Tabs PO Q 4 Hrs, PRN. DX: Mod pain" * "Tylenol (Acetaminophen) 325 - 650 mg Q 4, PRN. DX: Pain/temp"	F 329		

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F 329	Continued From page 22 The total potential daily dose from the Vicodin and Acetaminophen was 7,800 mg. No warnings not to exceed 4000 mg per day were found on the August 2008 MAR or recapitulation of physician orders. 4. Resident #2 was admitted to the facility on 5/24/08 with diagnoses of closed fracture of dorsal vertebrae, dementia without behaviors, anemia, and history of testicular cancer. Review of the August 2008 monthly recapitulation of physician orders and medication administration record revealed the following medications containing acetaminophen: * "Norco (Hydrocodone w/ [with] Acetaminophen) 10/325 mg 1/2 Tab PO BID [Twice per day]. DX: Pain" * "Norco (Hydrocodone w/Acetaminophen) 10/325 mg 1 Tab PO QID [Four times per day], PRN. DX: Mild pain" * "Norco (Hydrocodone w/Acetaminophen) 10/325 mg 2 Tabs PO QID, PRN. DX: Mod pain" * "Tylenol (Acetaminophen) 325 mg 2 Tabs PO Q 6 hrs, PRN. DX: Pain" The total potential daily dose from the Vicodin and Acetaminophen was 5,525 mg. No warnings not to exceed 4000 mg per day were found on the August 2008 MAR or recapitulation of physician orders. 5. Resident #6 was admitted to the facility on 6/2/06 and readmitted on 6/28/06 with diagnoses	F 329		

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F 329	Continued From page 23 of dementia, atrial arrhythmia, aortic aneurism, osteoarthritis and osteoporosis. According to the 8/1/08 recapitulation Physician Orders, Resident #6 received orders 1/26/07 for Xanax 0.125 mg twice daily at 8:00 am and 4:00 pm for general anxiety disorder. Resident #6's 4/29/08 annual MDS stated under Behavior - "wandering occurred daily." Resident #6's 7/13/08 quarterly MDS stated under Behavior - "wandering occurred daily." The 8/4/08 Care Plan Update for Resident #6 noted a functional decline with transfers, self propelling in wheel chair and feeding self. The 03/17/08 Comprehensive Care Plan Report (CP) intervention for potential trauma related to falls at night was updated on 5/1/08. Interventions included "assess risk of falls with antianxiety medications," "assess for side effects and notify MD of problems." On 8/11/08 at 3:10 pm Resident #6 was observed sleeping in her wheel chair in the 200 hall. At 3:15 pm, a CNA was observed taking the resident to her room. The CNA attempted to transfer the resident to bed. Resident #6 was lethargic and did not follow instructions to lean forward so the CNA could put gait belt on. The CNA left the room the to get help. The resident appeared to go back to sleep. At approximately 3:20 pm an LN arrived and awakened the resident, applied the gait belt and performed a squat pivot transfer of the resident from wheel chair to bed with verbal cues. The LN lifted both of the resident's feet onto bed. The resident fell asleep within a minute of lying down.	F 329		

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F 329	Continued From page 24 On 8/12/08 at 6.30 am Resident #6 was observed sleeping in bed. The resident was again observed sleeping in bed at 7:00 am, 7:15 am, 7:30 am and 7:45 am. At 8:45 am a CNA awakened resident #6 who expressed unwillingness to get up. The CNA informed resident she could stay in bed. Resident #6 was observed sleeping in bed at 9:50 am. On 8/13/08 Resident #6 was observed sleeping in the wheelchair at dining table from 5:35 pm to 5:55 pm. She awakened once to manipulate her clothing protector. The resident was observed sleeping from 6:10 pm till 6:20 pm when her food tray arrived. Resident #6's behaviors were described as intrusive wandering on the Monthly Behavior Summary/Psychoactive Gradual Dose Reduction Review (MBS). No episodes of intrusive wandering had been documented in 3/08 4/08, 5/08, 6/08 or 7/08. No dose reduction was recommended in any MBS for the five month period. According to the Medication Administration Record (MAR), Xanax was held for lethargy on 8/2/08 at 8:00 am and 4:00 pm., 8/5/08 at 8:00 am, 8/7/08 at 5:00 pm, 8/8/08 at 5:00 pm, 8/9/08 at 4:30 pm, 8/12/08 at 8:00 a.m. and held for sleepiness on 8/11/08 at 5:30 pm. During an interview 8/13/08 at 3:30 pm the social worker stated the facility did not track the resident's responses to Xanax for side effects but only tracked for its effect on wandering and elopement. This is a repeat citation from the June 5, 2007	F 329		

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F 329	Continued From page 25 recertification survey.	F 329		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to ensure appropriate infection control procedures were followed when a contaminated nasal cannula for oxygen therapy was placed on a resident. This affected one Random Resident (#25). The findings include: On 8/12/08 at 3:10 pm, Resident #25 was observed in a wheelchair in the hall outside of his room. A portable oxygen tank was mounted on the back of his wheelchair and his nasal cannula was observed to be on the floor near his wheelchair. The Administrator noticed the nasal cannula on the floor and picked it up, coiled it and placed it out of the resident's reach on the back of the wheelchair. He then instructed the visiting occupational therapist who would be working with Resident #25 not to place the contaminated nasal cannula on the resident and that a new nasal cannula would be brought to the resident. The	F 441	**F-441** **Resident Specific** Resident # 25's nasal cannula was replaced on 8/12/08. **Other Residents** Residents receiving oxygen therapy receive new nasal cannula in accordance to facility's Policy & Procedure, including PRN if contaminated. **Facility System** Interdisciplinary Team Members will be In-Serviced on facility's policy and procedure of replacing nasal cannula on routine basis and PRN if contaminated. **Monitoring** DNS or designee will monitor through routine rounds for compliance. Tracking and trending will be reported to facility's performance improvement committee for review and further recommendations.	09/18/08

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F 441	Continued From page 26 resident and the occupational therapist then entered the resident's room, along with the surveyor. The occupational therapist then began working with Resident #25. At 3:15 pm, the new nasal cannula had not yet arrived. At 3:20 pm, the resident was noticeably doing pursed lip breathing and the new nasal cannula had not yet arrived. The surveyor then left the room and went out into the hall, observing the doorway to see if a new nasal cannula would be brought to the resident. A second surveyor then immediately entered Resident #25's room and found that the contaminated nasal cannula had been placed on the resident. At 3:25 pm, a LN entered the room with a new nasal cannula while the occupational therapist was working with the resident and asked the resident if he needed it. Resident #25 answered that he needed a breathing treatment. The LN then left the new nasal cannula, still in the package, in the room and exited to see about a breathing treatment. On 8/14/08 at 9:30 am, the DON was made aware of the contaminated nasal cannula having been placed on Resident #25. At 3:00 pm on 8/14/08, the Administrator reported he had called the occupational therapist at another facility and confirmed that the occupational therapist had placed the contaminated nasal cannula on the resident, despite his instructions. This is a repeat citation from the June 5, 2007 recertification survey.	F 441		
F 445 SS=C	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 445	**F-445** **Resident Specific** The room identified is used occasionally for resident laundry. This room was cleaned and repainted. The sink was cleaned and refinished. The floor was retiled and re-waxed. The fan was cleaned.	09/18/08

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F 445	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility did not ensure a safe, sanitary and comfortable environment in the laundry. This had the potential to affect all residents whose laundry was done by the facility. Findings include: During the environmental review on 8/13/08 at approximately 1:10 pm, the following was observed in the facility: 1. A fan, heavily coated with dust and lint, was present in the clean linen area of the laundry room and blowing air over the clean linen folding table. 2. The floor in the small room adjacent to the laundry room was cluttered with boxes and cans and had dirt and lint buildup around the wall bases. 3. The sink and the exterior of the small washing machine in the small room adjacent to the laundry room was stained and coated with dust and lint. The laundry staff interviewed stated the small washing machine in that adjacent room was used to launder delicate clothing belonging to some residents. This is a repeat citation from the June 5, 2007 recertification survey.	F 445	**Other Residents** Above-mentioned repairs will provide a safe and sanitary environment for our residents. **Facility Systems** The Laundry Department was In-Serviced cleaning schedule for personal laundry room and cleaning schedule for fans. **Monitor** The Laundry Supervisor or designee will conduct weekly checks for one month, then randomly thereafter to ensure compliance. Results will be reported to the Performance Improvement Committee for tracking and trending and further recommendations.	
F 463 SS=F	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing	F 463	**F-463** **Resident Specific** The shower room call light system was repaired to light up at the main board. The system continued to work with light in hall above doorway as well as audible sound.	09/18/08

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F 463	Continued From page 28 facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility did not ensure that all portions of the call light system functioned properly for 5 of 5 shower rooms in all hallways. This affected all residents who used shower rooms. The findings include: On 8/13/08 at 1:05 pm, the maintenance director and two surveyors were checking the facility's call light system. After the surveyor activated the call light in each of five shower rooms in halls 100, 200, and 300, a second surveyor and the maintenance director observed that the panel lights at the nurses station failed to light. On 8/13/08 at 1:15 pm, the maintenance director was interviewed concerning the nurses station panel lights for the five shower rooms. The maintenance director stated that he had been checking the resident room call lights regularly, but had not checked the panel lights in the nurses stations for the five shower rooms in halls 100, 200 and 300. This is a repeat citation from the June 5, 2007 recertification survey.	F 463	**Other Residents** Above-mentioned repair provides a safe and fully functioning call light system for our residents. **Facility Systems** The Nursing Staff will be Re-In-Serviced on reporting any call light concerns using Maintenance Log. In-Service will be conducted before 9/19/08. **Monitor** The Preventative Maintenance Calendar has been updated to include monitoring the shower room call lights. The Maintenance Supervisor or designee will monitor shower call lights on routine basis to validate system is fully functional. Results will be reported to the Performance Improvement Committee for further recommendations.	
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	**F-514** **Resident Specific** Residents # 6 & 8's chart was updated to include required documentation for physical restraint monitoring and releasing.	09/18/08

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F 514	Continued From page 29 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility did not ensure clinical record documentation pertaining to the following were consistently documented: 1) 2 hour restraint release, this was true for 2 of 15 (#s 6 & #8) sampled residents. 2) Routine medications, this was true for 1 of 15 sampled residents (#14). Findings include: 1. Resident #14 was admitted to the facility on 3/13/05 and readmitted 3/20/08 with diagnoses of vascular dementia, chronic obstructive pulmonary disease, convulsions, depression and hemiplegia as a result of a cerebral vascular accident. The following medications, treatments and monitoring were not initialed by the LN on the 6/2008 Medication Records. It was not possible to determine if the medications/treatments were delivered on the following days: 6/9/08 - saline nasal spray, Lexapro 20 mg, Risperdal 1 mg, Flonase spray, Astelin spray, O2 sats, Duoneb inhaler 6/11/08 a.m.- pain evaluation, Potassium 20 meq, aspirin 325 mg, Lopressor 50 mg, Lasix 100 mg, Lisinopril 5 mg, Depakote Sprinkle 500 mg, saline	F 514	Resident # 14 – findings identified during the survey were from June, current Medication Administration and Treatment Record was reviewed to ensure completeness. **Other Residents** Residents using physical restraints were identified and charts reviewed to ensure documentation required for monitoring and releasing of physical restraints. Resident's Medication Administration and Treatment Administration records were reviewed to identify concerns with completeness. **Facility System** Nursing staff were re-educated on documentation requirements for residents that are physically restrained. In addition, licensed nurses were re-educated on necessity of documentation of medication and treatment administration according to physician's orders. **Monitoring** DNS or designee will audit documentation of medication and treatment administration and for residents that are physically restrained. Results of audits will be reported to facility's performance improvement committee for tracking and trending and further recommendations.	

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F 514	Continued From page 30 nasal spray, Lexapro 20 mg, Risperdal 1 mg, Flonase spray, Astelin spray, O2 sats, Duoneb inhaler 6/13/08 - saline nasal spray, Lexapro 20 mg, Risperdal 1 mg, Flonase spray, Astelin spray, O2 sats, Duoneb inhaler 6/20/08 - pain evaluation, saline nasal spray, Lexapro 20 mg, Risperdal 1 mg, Flonase spray, Astelin spray, O2 sats, Duoneb inhaler In addition, O2 sats were not documented for 6/16, 6/17, 6/18, 6/19, 6/23, 6/24, 6/25, 6/27, 6/29 and 6/30. The Administrator and DON were informed of the lack of documentation on 8/14/08 at 3:30 p.m. No further information was provided. 2. Resident #8 was admitted to the facility on 11/04/05 with diagnoses of advanced Alzheimer's disease, hypertension, coronary artery disease, and osteoarthritis. Resident #8's annual MDS assessment, dated 6/12/08, documented the following: * Short-term and long-term memory problems * Severely impaired cognitive skills for daily decision making * Total dependence on one person physical assist with transfers and toilet use * Extensive assistance of one person physical assistance with dressing * Chair restraint used daily to prevent rising The August 2008 recapitulated physician orders contained the order, dated 5/13/08, "Self-release seat belt for safety."	F 514		

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F 514	Continued From page 31 The resident's Interdisciplinary Physical Restraint Evaluation form, undated, documented the resident had difficulty with balance, and had the need for the restraint due to frequent falls, risk for fracture related to a history of cancer with metastasis to bones, and advancing Alzheimer's disease. The evaluation listed the type of restraint considered as a "Grey self-releasing seat belt," to be used when the resident was up in a wheel chair. Restraint free times were listed as, "Meal time, toileting, sleeping." Resident #8's care plan, dated 6/01/08, contained the problem, "Trauma, potential for R/T [related to] confusion, elopement risk, poor safety awareness, advancing alzheimer disease, and HX [history of] falls." One of the approaches, dated 6/20/07, documented, "Self release seat belt check and release Q 2 hr [every 2 hours] with cares if resident does not release it himself." During all observations on 8/12/08 between 7:30 am and 1:00 pm, Resident #8 was observed with a seat belt in place when he was up in his wheel chair, including meal times. The resident was observed to be resting on his bed at 9:15 am and then was again up in his wheelchair with the restraint on at 10:00 am. Resident #8's nursing records and flow sheets for July 2008 through August 13, 2008, did not document that Resident # 8 had periods of rest outside of the wheelchair, or that the seat belt was released every two hours and during meal times. On 8/14/08 at 9:30 am, the DON was interviewed and confirmed that 2 hours check and releases were not routinely documented but were done	F 514		

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F 514	Continued From page 32 during cares and times specified on the care plan. This is a repeat citation from the June 5, 2007 recertification survey. 3. Resident # 6 was admitted to the facility on 6/26/06, and readmitted on 6/28/06 with diagnoses of dementia, atrial arrhythmia, aortic aneurism, osteoarthritis and osteoporosis. The 7/13/08 quarterly MDS documented the following: short- and long -term memory problems, moderately impaired cognitive skills for daily decision making, extensive assistance for toileting, total dependence for transfers, fell in the previous 30 days, and daily use of a chair that prevented rising. Resident #6's care plan, dated 3/17/08, contained the problem, "Trauma, potential for R/T [related to] dementia, falls at night." One of the approaches, dated 6/12/08, documented, "Self release seat belt in w/c[wheelchair] check Q 2 hr [every 2 hours], release for toileting cares, when in bed." During all observations on 8/11/08 at 1:30 pm and 3:10 pm, on 8/12/08 at 10:00 am and 3:00 pm, 8/13 at 9:00 am and 3:40 pm, and from 5:45 pm to 6:15 pm Resident #6 was observed with a seat belt in place when up in the wheelchair, including meal time. Resident #6's nursing records and flow sheets for June, July and August 2008, did not document that resident # 6's seat belt was released every	F 514		

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	135051	A. BUILDING _____ B. WING _____	08/15/2008

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F 514	Continued From page 33 two hours. On 8/14/08 at 9:30 am, the DON was interviewed and confirmed that 2 hour releases were not routinely documented but were done during cares and times specified on the care plan. This is a repeat citation from the June 5, 2007 recertification survey.	F 514		

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State relicensure and complaint survey of your facility. The surveyors conducting the survey were: Mark Sawmiller, RN, Team Coordinator Lorraine Hutton, RN Janice Ryan, RN Lea Stoltz, QMRP Kari Davies, MPH, RD, LD Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record FSM = Food Service Manager	C 000	***This Plan of Correction is the centers credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** RECEIVED SEP - 8 2008 FACILITY STANDARDS	
C 125	02.100,03,c,ix ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 as it relates to dignity.	C 125	See F 241	09/18/08

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Executive Director

(X6) DATE: 9-8-08

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C 125	Continued From page 1	C 125		
C 143	02.100,05,c c. The patient/resident in mechanical restraints shall be checked at least every thirty (30) minutes by the staff and a record of such checks shall be kept. This Rule is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure 30 minute checks were conducted and documented while residents were restrained with wheelchair seatbelts. This was true for 3 of 15 sampled residents (#6, #8 and #10). Findings include: 1. Resident #6 was admitted to the facility on 6/2/06, and readmitted on 6/28/06, with diagnoses of dementia, atrial arrhythmia, aortic aneurism, osteoarthritis and osteoporosis. The 7/13/08 quarterly MDS documented the resident experienced short and long term memory problems, had moderately impaired cognitive skills for daily decision making, was totally dependent for transfers, required extensive assistance toileting and fell in the previous 30 days. Resident #6's 3/17/08 Care Plan interventions included "6/12/08 Velcro self release seat belt in W/C (wheelchair) - (check) q 2 (every 2 hours), release for toileting care, when in bed." Resident #6 was observed at varied times on 8/11/08 through 8/15/08. During observations the resident was noted to be wearing a self-releasing seat belt when seated in a wheelchair.	C 143	See F-514	09/18/08

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C 143	Continued From page 2 The DON was interviewed on 8/14/08 at 9:30 am and confirmed 30 minute checks were not conducted or recorded. 2. Resident #8 was admitted to the facility on 11/04/05 with diagnoses of advanced Alzheimer's disease, hypertension, coronary artery disease, and osteoarthritis. Resident #8's annual MDS assessment, dated 6/12/08, documented the following: * Short-term and long-term memory problems * Severely impaired cognitive skills for daily decision making * Total dependence on one person physical assist with transfers and toilet use * Extensive assistance of one person physical assistance with dressing * Chair restraint used daily to prevent rising The August 2008 recapitulated physician orders contained the order, dated 5/13/08, "Self-release seat belt for safety." The resident's Interdisciplinary Physical Restraint Evaluation form, undated, documented the resident had difficulty with balance, and had the need for the restraint due to frequent falls, a history of cancer with metastasis to bones, and advancing Alzheimer's disease. The evaluation listed the type of restraint considered as a "Grey self-releasing seat belt," to be used when the resident was up in a wheel chair. Restraint free times were listed as, "Meal time, toileting, sleeping." Resident #8's care plan, dated 6/01/08, contained the problem, "Trauma, potential for R/T [related to] confusion, elopement risk, poor safety awareness, advancing alzheimer disease, and	C 143		

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C 143	Continued From page 3 HX (history of) falls. "One of the approaches, dated 6/20/07, documented, "Self release seat belt check and release Q 2 hr [every 2 hours] with cares if resident does not release it himself." During all observations on 8/12/08 between 7:30 am and 1:00 pm, Resident #8 was observed with a seat belt in place when up in his wheel chair, including meal times. Resident #8's nursing records and flow sheets for July 2008 through August 13, 2008, revealed no documentation of the resident having 30 minute checks for his seat belt restraint. On 8/14/08 at 9:30 am, the DON was interviewed and confirmed that 30 minute checks were not being conducted or recorded. 3. Resident #10 was admitted to the facility on 12/22/05 and was readmitted on 2/16/08 with the diagnoses of senile delusion, dementia with behaviors, depression, anxiety, and benign prostatic hypertrophy with urinary retention. Resident #10's most recent annual MDS assessment, dated 8/10/08, documented the following: * Short-term and long-term memory problems * Severely impaired cognitive skills for daily decision making * Extensive assistance of one person for ambulation * Restraint use daily The August 2008 recapitulated physician orders contained the order, dated 2/16/08, "Grey belt while in W/C [wheelchair]." Resident #10's care plan, dated 4/23/08, contained the problem, "Trauma, potential for R/T	C 143		

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C 143	Continued From page 4 [related to] Dementia R/T High Fall Risk Especially at Night R/T Poor Safety Awareness R/T Balance Deficits." One of the approaches, dated 3/29/07, documented, "Grey belt while OOB/W/C [out of bed in wheelchair]. Check Q 2hr [every 2 hours] release to toilet or reposition/off load at this time." On 8/12/08 at 7:00 am, Resident #10 was observed in his room being transferred into his wheelchair by 2 CNAs using a Saralift. After the seat belt restraint was applied, one of the CNAs was asked if the resident could release the seat belt. The CNA answered that the resident "cannot release the belt." Review of Resident #10's record revealed that no mention was made of the resident having 30 minute checks for his seat belt restraint. On 8/14/08 at 9:30 am, the DON was interviewed and confirmed that 30 minute checks were not being conducted or recorded.	C 143		
C 145	02.10,05,e e. Opportunity for motion and exercise shall be provided to patients/residents in mechanical restraints for a period of not less than ten (10) minutes during each two (2) hours in which restraints are employed. This Rule is not met as evidenced by: Refer to F 514 as it relates to every 2 hour restraint checks.	C 145	See F-514	09/18/08
C 147	02.100,05,g	C 147	See F-329	09/18/08

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C 147	Continued From page 5 g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Refer to F329 as it relates to unnecessary drugs.	C 147		
C 357	02.108,06,c,i HANDLING OF CLEAN LINEN c. Handling of Clean Linen. i. Clean linen to be stored, dried, ironed, or sorted shall be handled in a sanitary manner. Clean linen and clothing shall be stored in a clean, dry, dust-free area easily accessible to the residential living area. This Rule is not met as evidenced by: Refer to F 445 as it refers to the handling of clean linens.	C 357	See F-445	09/18/08
C 360	02.108,06,d PERSONAL LAUNDRY d. Personal Laundry. Patients'/residents' and employees' laundry shall be collected, transported, sorted, washed, and dried in a sanitary manner and shall not be washed with bed linens. Patients'/residents' clothing shall be labeled to ensure proper return to the owner.	C 360	See F-445	09/18/08

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C 360	Continued From page 6 This Rule is not met as evidenced by: Refer to F 445 as it relates to resident's personal laundry.	C 360		
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Refer to F253 as it relates to housekeeping.	C 361	See F-445	09/18/08
C 409	02.120,05,i i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room. This Rule is not met as evidenced by: Based on observations of all rooms at the facility, it was determined the facility closets failed to meet the the state guidelines. The findings include:	C 409	We are requesting a waiver for the closet space.	09/18/08

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C 409	Continued From page 7 On 8/13/08 at approximately 1:00 pm, all rooms in the facility were checked for closet space. The closets were 16.5 x 23.75 inches. The resident group meeting with surveyors on 8/12/08 at 10:30 am did not indicate the closet space was a problem. The size of the closets created the potential that residents would not have sufficient space to store their clothing and other personal items in their closets.	C 409		
C 669	02.150,03 PATIENT/RESIDENT PROTECTION 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F441 as it relates to prevention of infections.	C 669	See F-441	09/18/08
C 674	02.151,01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal	C 674	See F-248	09/18/08

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C 674	Continued From page 8 activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Refer to F248 as it relates to activities before meals.	C 674		
C 762	02.200,02,c,ii ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift. This Rule is not met as evidenced by: Based on review of staffing records and staff interview, it was determined the facility did not ensure a registered nurse, other than the DON, worked the evening shift for 3 of 21 sampled days when the resident census ranged 86 to 89. This had the potential to effect all residents receiving care on those days. Findings include: The facility's Three Week Nursing Schedule dated 7/20 through 8/9/2008, documented no RN coverage for the evening shifts of 7/26, 7/27 and 8/02/2008. The census on those days was documented as 89, 89 and 86 respectively. On 8/13/08 at 9:15 am, the DON was informed that on the above three dates the schedule did not list a RN on duty during the evening shift. On 8/13/08 at 9:55 am, the DON verified a RN was	C 762	**C-762** **Resident Specific** All residents had the potential to be affected. **Other Residents** All residents had the potential to be affected. **Facility Systems** Staffing Scheduler has been instructed on the requirements for 16 hours of RN coverage. **Monitoring** The Director of Nursing or designee will review the schedule monthly to ensure RN coverage is in compliance.	09/18/08

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C 762	Continued From page 9 not on duty during the evening shifts of 7/26, 7/27 and 8/02. The DON stated she was in house on those shifts, but no other RN coverage was available.	C 762		
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to care plans.	C 782	See F-280	09/18/08
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it relates to fall prevention interventions.	C 790	See F-323	09/18/08
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it relates to accurate record keeping.	C 881	See F-514	09/18/08